U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 10 April 2007

In the Matter of:

S.M.[1], Case No. : 2000-BLA-00727
Claimant
v.
EASTERN COAL COMPANY,
Employer
and
DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS
Party-in-Interest

DECISION AND ORDER ON REMAND

On August 23, 2004, a Decision and Order Awarding Benefits was issued by Administrative Law Judge Richard E. Huddleston. On appeal, the Decision was vacated in part and affirmed in part, and the case was remanded by Decision and Order of the Board ("Board"), BRB No. 04-0490 BLA, issued on September 28, 2005.

By Order dated March 22, 2006, Judge Huddleston required the parties to submit briefs by May 22, 2006, addressing consideration of the case on remand. Claimant filed a Response to Order on May 11, 2006, stating that the Claimant did not desire a new hearing and requesting a decision on the record. On May 18, 2006, the Employer responded stating it did not desire a new hearing and that it also preferred a decision on the present record. The Employer requested that the administrative law judge issue an order allowing the filing of briefs on remand. On May 24, 2006, Claimant also requested a new briefing schedule to address the issues on remand.

Subsequent to the Board's decision, Judge Huddleston retired and was unavailable to hear this case on remand. By Order dated June 9, 2006, the above captioned case was transferred to me for disposition.

In its Decision and Order, the Board affirmed the administrative law judge's findings that the Miner established 13-1/3 years of coal mine employment, the existence of simple pneumoconiosis arising out of coal mine employment, and that the Claimant failed to establish total respiratory disability under § 718.204(c)(2000).[2]

When reviewing the administrative law judge's analysis of complicated pneumoconiosis under § 718.304, the Board held that

> prior to considering all of the relevant evidence, … the administrative law judge did not first evaluate the evidence in each category, rendering it unclear as to which evidence he ultimately relied upon, and the basis for his reliance. Accordingly, we remand this case, and initially instruct the administrative law judge to evaluate the evidence in each category of section 718.304(a) and (c), before weighing all relevant evidence together to determine whether or not invitation as established. *S.M. v. Eastern Coal Corp*., BRB No. 04-0940 at 5.

The Board noted that the record does not contain biopsy evidence that would establish the existence of complicated pneumoconiosis under § 718.304(b).

The Board held that it was unclear which evidence the administrative law judge ultimately relied upon in establishing the existence of complicated pneumoconiosis at § 718.304(a). *Id*. at 6. The Board instructed that, on remand, a detailed analysis be provided for his crediting or discrediting each x-ray interpretation and an explanation be provided explaining which x-ray interpretations Judge Huddleston ultimately relied upon to support his finding of the existence or absence of complicated pneumoconiosis. *Id*. the Board also was critical of Judge Huddleston's analysis of several medical opinions of record and with his decision to discredit the interpretations of a November 17, 1999, CT scan.

Findings of Fact and Conclusions of Law

The Findings of Fact and Conclusions of Law as stated in the August 23, 2004, Decision and Order are adopted herein except to the extent they were found to be erroneous by the Benefits Review Board, or to the extent that they are inconsistent with the findings and conclusions made in this Decision and Order on Remand.

Complicated Pneumoconiosis

Pursuant to Section 718.304(a) the existence of complicated pneumoconiosis may be established when diagnosed by a chest x-ray which yields one or more large opacities (greater than 1 centimeter) and would be classified in Category A, B, or C. X-ray evidence is not the exclusive means of establishing complicated pneumoconiosis under Section 718.304. Its existence may also be established under Section 718.304 (b) by biopsy or autopsy or under Section 718.304 (c), by an equivalent diagnostic result reached by other means. The Benefits Review Board has held that it must first be determined whether the relevant evidence in each category tends to establish the existence of complicated pneumoconiosis and then the evidence at each subsection must be weighed together before determining whether invocation of the irrebuttable presumption under Section 718.304 has been established. *Melnick v. Consolidated Coal Co*., 16 B.L.R. 1-31, 1-33 (1991) (en banc). The United States Court of Appeals for the Fourth Circuit has held that "…even where some x-ray evidence indicates opacities that would satisfy the requirements of prong (A), if other x-ray evidence is available or if evidence is available that is relevant to an analysis under prong (B) [biopsy or autopsy] or prong (C) [other means] then all the evidence must be considered and evaluated to determine whether the

evidence as a whole indicates a condition of such severity that it would produce opacities greater than one centimeter in diameter on an x-ray." *Eastern Associated Coal Corp. v. Director, OWCP (Scarbro)*, 220 F. 3d 250, 256 (4th Cir. 2000).

Pneumoconiosis is a progressive and irreversible disease. *Labelle Processing Co. v. Swarrow*, 72 F.3d 308, 314-315 (3rd Cir. 1995); *Lane Hollow Coal Co. v. Director, OWCP*, 137 F.3d 799, 803 (4th Cir. 1998); *Woodward v. Director, OWCP*, 991 F.2d 314, 320 (6th Cir. 1993). As a general rule, therefore, more weight is given to the most recent evidence. See *Mullins Coal Co. of Virginia v. Director, OWCP*, 484 U.S. 135, 151-152 (1987); *Eastern Associated Coal Corp. v. Director, OWCP*, 220 F.3d 250, 258-259 (4th Cir. 2000); *Crace v. Kentland-Elkhorn Coal Corp*., 109 F.3d 1163, 1167 (6th Cir. 1997); *Rochester & Pittsburgh Coal Co. v. Krecota*, 868 F.2d 600, 602 (3rd Cir. 1989); *Stanford v. Director, OWCP*, 7 B.L.R. 1-541, 1-543 (1984); *Tokarcik v. Consolidated Coal Co*., 6 B.L.R. 1-666, 1-668 (1983); *Call v. Director, OWCP*, 2 B.L.R. 1-146, 1-148-1-149 (1979). This rule is not to be mechanically applied to require that later evidence be accepted over earlier evidence. *Woodward*, 991 F.2d at 319-320; *Adkins v. Director, OWCP*, 958 F.2d 49 (4th Cir. 1992); *Burns v. Director, OWCP*, 7 B.L.R. 1-597, 1-600 (1984).

As discussed above, the evidence is insufficient to establish the existence of complicated pneumoconiosis under § 718.304(b). *M. v. Eastern Coal Co*., 04-0940 BLA at 5. The analysis below, therefore, will focus on § 718.304(a) and (c).

Chest X-rays under § 718.304(a)[3]

Chest x-rays may reveal opacities in the lungs caused by pneumoconiosis and other diseases. Large opacities (greater than 1 cm) may be classified as A, B or C, in ascending order of size, and may be evidence of "complicated pneumoconiosis."

In review of Judge Huddleston's Decision and Order on Remand, the Board held that it was not apparent from his analysis which specific x-ray interpretations he relied upon to find existence of complicated pneumoconiosis. The Board ordered a detailed analysis for the crediting or discrediting of each x-ray interpretation and an explanation articulating which x-ray interpretations he relied on to support his finding of the existence or absence of complicated pneumoconiosis. As previously mentioned, Judge Huddleston has retired; and as the Board noted, it is not apparent which specific x-rays he relied upon in support of his finding of complicated pneumoconiosis. Accordingly, the x-ray evidence has been reviewed de novo,

As the prior Decision and Order noted, the record contains 61 x-ray interpretations. The chart listing each x-ray interpretation from the August 24, 2004, Decision and Order on Remand (*see* pages 6-10) is incorporated herein by reference.

In cases involving conflicting x-ray evidence, the regulations specifically provide,

> … where two or more X-ray reports are in conflict, in evaluating such X-ray reports consideration shall be given to the radiological qualifications of the physicians interpreting such X-rays. 20 CFR §

718.202(a)(1) (2005); *Dixon v. North Camp Coal Co*., 8 B.L.R. 1-344 (1985); *Melnick v. Consolidation Coal Co*., 16 B.L.R. 1-31, 1-37 (1991).

Readers who are board-certified radiologists and/or B-readers are classified as the most qualified. The qualifications of a certified radiologist are at least comparable to if not superior to a physician certified as a B-reader. *Roberts v. Bethlehem Mines Corp.*, 8 B.L.R. 1-211, 1-213 n.5 (1985). Greater weight may be accorded to x-ray interpretations of dually qualified physicians. *Sheckler v. Clinchfield Coal Co*., 7 B.L.R. 1-128, 1-131 (1984). Consider may be given to the number of interpretations on each side of the issue, but not to the exclusion of a qualitative evaluation of the x-rays and their readers. *Woodward*, 991 F.2d at 321; *see Adkins*, 958 F.2d at 52.

The January 21, 1981, x-ray was interpreted as negative for pneumoconiosis by Dr. Levy, who lists no radiographic credentials. As this is the oldest film of record and the reviewing physician lists no specialty credentials for interpreting x-rays, I give this film some weight and find that this interpretation does not support a finding of complicated pneumoconiosis.

The July 10, 1984, x-ray film was interpreted as negative for pneumoconiosis by Dr. Srisumrid, a Board-certified Radiologist. As this film is over 20 years old, I note Dr. Srisumid's credentials, and find that his negative interpretation is due some weight.

The October 26, 1985, x-ray film was interpreted by 20 physicians. I initially afford less weight to the interpretations by Drs. Anderson, Ameji, and Wright, as they offer no x-ray specialty credentials in the record. I also assign less weight to the interpretation by KHA (*See* DX 37, p. 16). The name of this physician is not listed, and his credentials as a B reader cannot be confirmed. I also give less weight to the interpretations by Drs. Broudy, Sargent, Rosenberg, and Repsher. The Board affirmed the existence of simple pneumoconiosis. Since these physicians found no pneumoconiosis whatsoever, it would not be possible for them to diagnose complicated pneumoconiosis in their opinions.

Dr. Robinette, a B reader, interpreted this film as demonstrating simple pneumoconiosis only. I give this interpretation some weight on the issue of complicated pneumoconiosis.

The record contains 11 interpretations by physicians who are both B readers and Board-certified Radiologists. Drs. Kenard, Fisher, Bassali, and Aycoth diagnosed complicated pneumoconiosis with Category A large opacities. Drs. Brandon, Cole, Marshall, Mathur, Jakobson, and Deardorff diagnosed simple pneumoconiosis only.

Drs. Brandon, Mathur, and Marshall offered no further analysis of their interpretations. Dr. Cole and Dr. Deardorff did not diagnose complicated pneumoconiosis, but instead noted a coalescence of pneumoconiotic opacities. Dr. Jakobson noted that TB had to be considered in evaluating this film, and he noted a questionable mass in the aortic pulmonary window which could represent cancer.

Of the 11 interpretations by dually certified physicians, four diagnosed complicated pneumoconiosis while 7 diagnosed simple pneumoconiosis only. With identical qualifications, the quantity of negative to positive evaluations is significant. Further, the 20 interpretations of this film ranged from no pneumoconiosis at all, to simple pneumoconiosis, to simple pneumoconiosis with alternative explanations for other readings on the film, to a diagnosis of complicated pneumoconiosis. Eleven Board-certified Radiologists and B readers do not agree on the interpretation of this film and they do not offer explanations or rationale to sway the trier of fact. Accordingly, having considered the qualitative factors, it appears that the quantitative weight of the evidence provided by the "B" readers interpreting the October 26, 1985 x-ray, indicates it is, on balance, negative for complicated pneumoconiosis.

The May 14, 1986, x-ray film was interpreted as negative for complicated pneumoconiosis by Dr. Srisumrid, a Board-certified Radiologist and B reader. With no conflicting interpretations in the record, I find that this film is negative for complicated pneumoconiosis.

The December 1, 1986, x-ray film was interpreted by seven physicians. No physician of record interpreted this film as positive for either simple or complicated pneumoconiosis. While I note that the existence of simple pneumoconiosis has already been established, I find that this film does not support the existence of complicated pneumoconiosis.

The January 19, 1987, x-ray film was interpreted by Dr. Harrison, a B reader. Dr. Harrison noted numerous small, rounded and irregular opacities which appeared to be coalescent. He "could not rule out" the existence of pneumoconiosis and suggested that the Claimant undergo further pulmonary evaluation. Dr. Harrison did not elaborate on the size of the opacities noted, and his diagnosis is equivocal at best. I find that this film does not support the existence of complicated pneumoconiosis.

The February 18, 1987, x-ray film was reviewed by four physicians. Dr. Repsher found this film unreadable, and he offered no interpretation. Drs. Broudy and Rosenberg, both B readers, found no pneumoconiosis at all. Dr. Spitz, a dually certified physician, interpreted the film as "possibly" showing a large opacity on the right and "possibly" a slightly smaller one on the left, and he recommended further evaluation of the Claimant to obtain a TB history. Dr. Spitz's statements are equivocal, and his only real interpretation is that further evaluation of the Claimant's medical history is required to interpret the opacities seen on the film. I find that this film does not support the existence of complicated pneumoconiosis.

The May 7, 1987, x-ray film was reviewed by four physicians. Dr. Wiot found the film unreadable, and he offered no interpretation. Dr. Mettu, who lists no radiographic credentials, diagnosed the film as showing simple pneumoconiosis only. I give his interpretation some weight. Drs. Poulos and Sargent, both Board-certified Radiologists and B readers, interpreted the film as showing simple pneumoconiosis only. **Dr. Felson, a** Board-certified Radiologist and B reader, interpreted the film as showing complicated pneumoconiosis, Category A large opacities, and noted probable pneumoconiosis, although sarcoidosis is not excluded. In review of the dually certified physicians, two interpretations were negative for complicated pneumoconiosis while one interpretation was positive. Dr. Felson, however, noted "probable"

pneumoconiosis and did not rule out other alternatives to the opacities seen. I find that the preponderance of dually certified interpretations of this film do not support a finding of complicated pneumoconiosis.

The August 6, 1987, x-ray film was interpreted by five physicians. None diagnosed complicated pneumoconiosis, and I find that this film does not support a finding of complicated pneumoconiosis.

The April 27, 1991, x-ray film was interpreted by six physicians. No physician of record interpreted this film as showing either simple or complicated pneumoconiosis. I find that this film does not support a finding of complicated pneumoconiosis.

The October 20, 1999, x-ray film was interpreted by five physicians. Dr. Rosenberg diagnosed "apparent" linear and nodular densities but diagnosed no pneumoconiosis based on other clinical information in the record. Dr. Broudy, a B reader, diagnosed pneumoconiosis, but rated the film as "3" or poor. If a physician marks "3", "U/R", or in some cases a "-", then the x-ray study may be accorded little or no probative value as it is of poor quality. *Gober v. Reading Anthracite Co.,* 12 B.L.R. 1-67 (1988). Other readers found this x-ray to be of sufficient quality to merit probative value. I give these two interpretations some weight and find that they do not support the existence of complicated pneumoconiosis. Dr. Younes, a B reader, interpreted this film as showing Category A large opacities, but he recommended a CT scan of the chest for further clarification. Dr. Sargent, who is dually certified, diagnosed simple pneumoconiosis, noted other conditions, and he also recommended additional studies for clinical correlation to make a final determination. Dr. Barrett, a Board-certified Radiologist and B reader, interpreted this film as showing Category B large opacities. I find that while interpretations of large opacities are made by two physicians on this film, two of the interpreting physicians conditioned their opinion on the need for further studies to make a final determination of what the masses seen actually represent. I find that **this film is inconclusive** on the issue of complicated pneumoconiosis.

The **November 17, 1999,** x-ray film was interpreted by four physicians. Drs. Broudy and Repsher, both B readers, interpreted the film as negative for complicated pneumoconiosis. Drs. Miller and Alexander, both Board-certified Radiologists and B readers, interpreted the film as positive for complicated pneumoconiosis. I give greater weight to the dually certified radiologists who are also B readers, and find that the November 17, 1999, x-ray evidence **is positive for complicated pneumoconiosis**.

Taken as a whole, the record contains ten negative x-rays, one inconclusive x-ray, and one positive x-ray. In review by Board-certified Radiologists and B readers, there were 18 negative interpretations for complicated pneumoconiosis, and eight positive interpretations for complicated pneumoconiosis. Because pneumoconiosis is a progressive and irreversible disease, it is often appropriate to give greater weight to the most recent evidence of record, especially where a significant amount of time separates newer evidence from that evidence which is older. *Clark v. Karst-Robbins Coal Co*., 12 B.L.R. 1-149 (1989)(en banc); *Casella v. Kaiser Steel Corp*., 9 B.L.R. 1-131 (1986). The x-rays in this case are dated from 1981 through 1999. The most recent November 17, 1999, x-ray was found to be positive for complicated

pneumoconiosis. Although the October 20, 1999, film was found to be inconclusive as a whole, this recent x-ray also has two positive interpretations for complicated pneumoconiosis.

The remaining x-rays are from 1981-1991. I give greatest weight to the most recent x-ray evidence, noting that it represents by eight years, the most recent x-ray evidence of the Claimant's current medical condition. I find that x-ray evidence supports a finding of complicated pneumoconiosis under § 718.304(a).

X-ray evidence, however, is the "least accurate method" of diagnosing complicated pneumoconiosis, and, therefore, all relevant evidence be weighed prior to invoking the irrebutable presumption of total disability due to pneumoconiosis under the Act. *Gray v. SLC Coal Co*., 176 F.3d 382 (6th Cir. 1999).

Other Evidence Under § 718.304(c)

The Board held that Judge Huddleston's analysis of several medical opinions of record was inconsistent and that the rationale supporting or discrediting particular opinions was inadequate to affirm the analysis as a whole. The records from Williamson Appalachian Regional Hospital, and the opinions of Drs. Shafer, Parr, Mettu, Srisumrid, Saergent, Fino, Wright, and Polisetty were not directly challenged on appeal and the Board did not disturb the finding that these opinions do not support a finding of complicated pneumoconiosis.

Dr. James K. Cooper diagnosed simple pneumoconiosis in 1986, based, in part, on the Claimant's statement that a 1985 skin test was negative for tuberculosis. I find that Dr. Cooper's opinion does not support a diagnosis of complicated pneumoconiosis. Noting the age of this opinion and the fact that it is based in part on unconfirmed lay statements regarding the existence of tuberculosis, I give Dr. Cooper's opinion less weight.

Dr. Harrison examined the Claimant in 1987 and opined that the Miner's abnormal x-ray may not be coal workers' pneumoconiosis but also could represent tuberculosis or sarcoidosis. At deposition, Dr. Harrison clarified his opinion, stating that the Claimant's relatively young age (40 at that time), the length of coal mine employment, and the hilar adenopathy seen on the x-ray was more consistent with granulomatous disease than pneumoconiosis. Dr. Harrison based his opinion on medical history, physical examination, x-ray results, length of coal dust exposure, and smoking history. He documented which readings supported a finding of no pneumoconiosis and explained the basis for alternative diagnoses. I find Dr. Harrison's report to be well reasoned, based upon the medical data available in his examination, and I find that his report does not support a finding of complicated pneumoconiosis.

Dr. Robert Abernathy diagnosed probable coal workers' pneumoconiosis based on a positive x-ray interpretation, but stated that the x-ray reviewed could also represent pulmonary tuberculosis. He recommended further investigation to clarify what condition was causing the abnormal x-ray readings. As Dr. Abernathy's opinion does not diagnose complicated pneumoconiosis, and indeed offers no definitive interpretation, I give his opinion little weight.

Dr. Lane performed a records review at the request of the Employer and diagnosed coal workers' pneumoconiosis with possible tuberculosis and sarcoidosis. He did not further explain his diagnosis. I note Dr. Lane's multiple diagnoses, and also note that he did not diagnose complicated pneumoconiosis. Given Dr. Lane's limited explanation of his diagnosis, and the fact that he did not diagnose complicated pneumoconiosis, I give his opinion less weight, and find that it does not support the existence of complicated pneumoconiosis.

Dr. Vuskovich, a Board-certified Occupational Medicine Specialist and a B reader, and diagnosed hyperlipidemia with abnormal lipid profile, and status post active tuberculosis. He noted extensive fibrotic changes in both apices with distortion of the hilar structure. He opined that none of the diagnosed conditions related to coal mine employment. Dr. Vuskovich examined the Claimant and based his opinion on x-ray evidence, medical histories, and physical examination. While I note his superior credentials, I give little weight to his opinion great weight, because the Board has found that Claimant does have simple pneumoconiosis, a condition related to coal mine employment which Dr. Vuskovich was unable to detect.

Dr. Rosenberg performed a records review and was deposed for this claim. He reviewed the evidence from the mid-1980s to 2000, and noted a progression of fibrotic scarring with large opacity formation. He opined, however, that there is a difference between recording abnormalities and interpreting such findings. He explained that the presence of upper lobe abnormalities without a background of small nodular opacities, made the existence of pneumoconiosis improbable. He noted that the 1999 CT scan of the chest was negative for simple or complicated pneumoconiosis. As the x-ray and CT scan evidence does not support a finding of pneumoconiosis, he opined that the abnormal x-ray findings most likely relate to old granulomatous disease, sarcoidosis, and/or tuberculosis. He noted that a negative tuberculosis skin test was not dispositive of whether a patient had prior tuberculosis and that newly diagnosed patients also can have negative skin tests.

Dr. Rosenberg is a Board-Certified Internist and Pulmonologist. He based his opinion on review of a large volume of medical evidence collected over a 15 year period. He noted the progression of abnormal x-ray interpretations, and used other objective evidence and explanation to document why he felt the evidence did not support a diagnosis of complicated pneumoconiosis. Noting Dr. Rosenberg's superior credentials, I afford his opinion great weight, and find that it does not support a finding of complicated pneumoconiosis.

Dr. Repsher performed a records review at the request of the Employer and was deposed for this claim. Dr. Repsher opined that the Miner showed no evidence of pneumoconiosis, but did exhibit evidence of biapical graulomatous disease which progressed over time, evidence of COPD or emphysema, and possible tuberculosis. He opined that the conglomerate lesions observed in the apices of the lungs were typical of tuberculosis. He noted negative TB tests in the record, and noted that they did not preclude the existence of atypical tuberculosis or some other form of biapical granulomatous disease such as sarcoidosis, or histoplasmosis. He opined that x-rays showed a stable condition since 1996, which was more consistent with healed tuberculosis or other graulomatous disease, and less consistent with the progressive nature of pneumoconiosis. Dr. Repsher based his opinion on objective evidence, and he explained why he felt the abnormalities seen were not consistent with the progressive nature of pneumoconiosis.

Although Dr. Repsher failed to diagnose even simple pneumoconiosis, he does discuss the conglomerated lesions in claimant's lungs, and accordingly I accord his opinion against a finding of complicated pneumoconiosis moderate weight.

Dr. Broudy examined the Claimant and was deposed twice for this claim. Dr. Broudy opined that the Miner does not suffer from pneumoconiosis. He noted a negative history of tuberculosis, and he attributed x-ray abnormalities to healed inflammatory disease, most likely due to previous granulomatous disease from tuberculosis or histoplasmosis. In his second deposition, Dr. Broudy explained that a current negative tuberculosis test does not rule out previous granulomatous disease which had healed leaving scarring on the lungs. He discussed his positive x-ray interpretation of the October 20, 1999, x-ray film, noting that the film was of poor quality, and that, when viewing this positive film, in conjunction with other films of the same time period and a negative CT scan from November 1999, his final diagnosis was healed granulomatous disease. Dr. Broudy based his opinion on objective evidence and he documented which readings supported his diagnosis. In two depositions, he clarified his opinion, explaining why the abnormalities seen were not, in his opinion, consistent with pneumoconiosis. Although Dr. Broudy failed to diagnose even simple pneumoconiosis, he does discuss the lesions in claimant's lungs, and accordingly I accord his opinion against a finding of complicated pneumoconiosis moderate weight.

Dr. Nadorra was one of the miner's treating physicians. "[T]he opinions of treating physicians are not necessarily entitled to greater weight than those of non-treating physicians in black lung litigation." *Eastover Mining Co. v. Williams*, 338 F.3d 501 (6th Cir. 2003). "[I]n black lung litigation, the opinions of treating physicians get the deference they deserve based on their power to persuade." *Id*. at 510; 20 C.F.R. § 718.104(d). "A highly qualified treating physician who has lengthy experience with a miner may deserve tremendous deference, whereas a treating physician without the right pulmonary certifications should have his opinion appropriately discounted." *Id*. In addition, appropriate weight should be given as to whether the treating physician's report is well-reasoned and well-documented. *See Peabody Coal Co. v. Groves*, 277 F.3d 829 (6th Cir. 2002); *McClendon v.Drummond Coal Co.*, 12 B.L.R. 2-108 (11th Cir. 1988). The record contains multiple treatment notes dating from 1992- 1999. During multiple visits in 1992, lungs were consistently observed to be clear, and a notation was made for coal workers' pneumoconiosis and discoid lupus. During office visits in 1993, simple pneumoconiosis was noted in the record, and the miner was diagnosed with acute bronchitis several times. Additional notations were made in 1994 in 1995 for acute bronchitis. The Claimant suffered from pneumonia in 1995 and in 1996. Coal workers' pneumoconiosis was noted in all submitted years. Dr. Nadorra diagnosed complicated pneumoconiosis on September 13, 2000. He offered no basis for that diagnosis.

Dr. Nadorra presents no specialty credentials in the record. While he noted simple pneumoconiosis over an extended period of time, he did not document or explain the basis of that diagnosis. Likewise, when he diagnosed complicated pneumoconiosis in 2000, he did not explain the basis for that diagnosis nor did he document the evidence relied on to reach that conclusion. As noted by the Board, Dr. Nadorra also did not document the duration of the claimant's smoking history. *Eastern Coal Co*., BRB No. 04-0940 BLA at 12. I note Dr. Nadorra's lengthy experience as claimant's treating physician, but I find his opinion not well

reasoned and to be poorly documented. I give his opinion regarding the presence of complicated pneumoconiosis diminished weight.

Dr. Younes was also a treating physician. Dr. Younes based his opinion, in part, on the Miner's statement that he was a non smoker. The physicians of record recorded an average smoking history of about twenty pack-years. It is proper for an ALJ to discredit a medical opinion based on an inaccurate smoking history. *Trumbo v. Reading Antracite Co*., 17 B.L.R. 1-85(1993). As discussed by the Board, "Section 718.304 defines complicated pneumoconiosis as a chronic dust disease of the lung, [and therefore] it is important that a physician have accurate knowledge of any other causes, apart from coal dust exposure, that could result in a chronic disease of the lung, prior to rendering a conclusion on whether or not a claimant suffers from complicated pneumoconiosis." *Eastern Coal Co*., BRB No. 04-0940 BLA at 12. I find Dr. Younes report to be based on an inaccurate smoking history, and I afford his opinion diminished weight.

CT Scans

The Department of Labor has rejected the view that a CT-scan, by itself, "is sufficiently reliable that a negative result effectively rules out the existence of pneumoconiosis." 65 Fed. Reg. 79, 920, 79, 945 (Dec. 20, 2000). Therefore, a CT-scan, while arguably the most sophisticated and sensitive test available must still be measured and weighed based upon the radiological qualifications of the reviewing physician. *Consolidation Coal Co. v. Director, OWCP [Stein],* 294 F.3d 885 (7th Cir. 2002). CT scans are not subject to the specific requirements for evaluation of x-rays, and must be weighed with other acceptable medical evidence. *Melnick v. Consolidation Coal Co*., 16 B.L.R. 1-31, 1-33-1-34 (1991). The record in this case contains one November 17, 1999 CT scan. Drs. Broudy, Repsher, and Rosenberg, all B readers, interpreted the CT scan as negative for both simple and complicated pneumoconiosis. I find that CT scan evidence weighs against a finding of complicated pneumoconiosis.

In review of the other medical evidence under § 718.304(c), I find that these records do not support a finding of complicated pneumoconiosis. The only physicians of record who opined that the Miner suffers from complicated pneumoconiosis, Drs. Nadorra and Younes, submitted poorly reasoned opinions. The 1999 CT scan, among the most recent medical evidence of the Claimant's current condition, does not support a finding of complicated pneumoconiosis. No other physician of record diagnosed complicated pneumoconiosis.

When reviewing this evidence in combination with the x-ray evidence, I note that x-ray evidence is supportive of complicated pneumoconiosis. Many physicians opined, however, that determining the presence of x-ray abnormalities is only the first step in analyzing the Claimant's ailment. To properly understand what is seen on x-ray, they opined that the reviewing physician must examine all of the patient's clinical evidence to properly determine the nature and cause of the x-ray abnormalities. The well-reasoned medical opinions in this record weigh preponderantly against the conclusion that the x-ray abnormalities were caused by complicated pneumoconiosis. I, therefore, find that the Claimant has not established the existence of complicated pneumoconiosis, and therefore, is not entitled to the presumptions associated with that diagnosis under the Act.

Entitlement

S.M., the Claimant, has established the existence of simple pneumoconiosis arising out of coal mine employment, but has not established total respiratory disability or the existence of complicated pneumoconiosis. Claimant, therefore, is not entitled to benefits under the Act.

Order

IT IS, THEREFORE, ORDERED that the claim of S.M. for benefits under the Act be, and it hereby is, DENIED.

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Stuart A. Levin
Administrative Law Judge

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[1] Effective August 1, 2006, the U. S. Department of Labor implemented a policy to avoid using claimants' names in the caption or body of any Black Lung or Longshore decision or order. In lieu of identifying the claimant by name, the policy requires the use of the claimant's initials.

[2] The provision pertaining to total disability, previously set out at § 718.204(c)(2000), is now found at § 718.204(b) in the new regulations, while the provision pertaining to disability causation, previously set out at § 718.204(b)(2000), is now found at § 718.204(c) in the new regulations.

[3] As the Board affirmed the existence of simple pneumoconiosis, discussion of x-ray evidence will be limited to the weighing of the interpretation on the issue of complicated pneumoconiosis.

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with the decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the administrative law judge's decision is filed with the district director's office. See 20 C.F.R. §§ 725.478 and 725.479. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, DC 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. See 20 C.F.R. §802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Allen Feldman, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N 2117, Washington, DC 20210. See 20 C.F.R. § 725.481.

If an appeal is not timely filed with the Board, the decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. §725.479(a).